

18. Address:

*Number and Street

*City

State

Zip

19. Home phone number:

()

20. Nearest Relative:

*Last

First

Middle

21. Relationship to you:

22. Relatives Address:

Number and Street

*City

State

Zip

23. Your preferred primary language:

☐ English

☐ Spanish

☐ Chinese

☐ Japanese

☐ Korean

☐ Vietnamese

☐ Tagalog

☐ Sign Language

☐ Other

24. Where were you referred from?

25. Employment status:

☐ Full time, 35 hours or more weekly (competitive job market)

☐ Part time, less than 35 hours a week (competitive job market)

☐ Full time, 35 hours or more weekly (non-competitive job market)

☐ Part time, less than 35 hours a week (non-competitive job market)

☐ Unemployed

☐ Not in labor force (homemaker, student, retired, etc.)

☐ Unknown

26. Employer:

27. Employer's phone number:

()

28. Check and circle the highest level of education:

☐ Elementary K 1 2 3 4 5 6 7 8

☐ High School 9 10 11 12

☐ College 1 2 3 4

☐ Graduate School 1 2 3 4 (or more)

☐ Other

☐ Unknown

29. Disability

☐ None

☐ Speech Impairment

☐ Blindness or Severe Visual Impairment

☐ Physical Impairment – Mobility

☐ Deaf or Severe Hearing Impairment

☐ Unknown Related

30. Who is financially responsible for this bill?

*Last Name

First

Middle

31. Address

*Number and Street

*City

State

Zip

32. Employer

33. What is your insurance company

☐

☐ Medi-Cal

☐ Medicare

34. Are you carrying a weapon such as a gun or knife

☐ Yes

☐ No

35. Do you receive Veterans benefits?

☐ Yes

☐ No

For office use only*

Care Coordinator

UMDAP

Yearly Liability

Renewal Date

Financial Classification

County of San Diego
Health and Human Services Agency
Mental Health Services

CLIENT QUESTIONNAIRE

HHSA:MHS-916 (06/2003)

Client:

MR/Client ID #:

Program: